

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05284

CERTIFICATE OF DEATH

05273

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 40 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veneron Apts.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALICE B. Middle BAXTER Last				4. DATE OF DEATH Month May Day 28 Year 1957			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1875	9. AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Reading Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John--Bell Nelson Bell				14. MOTHER'S MAIDEN NAME Ellen Cochell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Ruth C. Bordley, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerotic C V Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1						INTERVAL BETWEEN ONSET AND DEATH one month 2 or 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/18 , 19 57 , to 5/28 , 19 57 , that I last saw the deceased alive on 5/28 , 19 57 , and that death occurred at 6:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Robert W. Farr M.D. 5/30/57							
PHYSICIAN'S NAME (Type) Robert W. Farr, M. D., Chestertown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 30, /57		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams Chestertown, Md.				24a. REC'D BY REGISTRAR May 31-1957		24b. REGISTRAR'S SIGNATURE Clara S. Barnes	

CERTIFICATE OF DEATH

1957

NAME OF DECEASED JAMES E. BARRY		DATE OF DEATH JUN 21 1957	
PLACE OF DEATH HOSPITAL		CITY NEW YORK	
AGE 45		SEX MALE	
RACE WHITE		RELIGION METHODIST	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL	
OCCUPATION ENGINEER		MILITARY SERVICE NONE	
CAUSE OF DEATH CORONARY THROMBOSIS		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. E. BARRY		SIGNATURE OF WITNESSES J. E. BARRY	
DATE OF SIGNATURE JUN 21 1957		PLACE OF SIGNATURE HOSPITAL	
SIGNATURE OF DECEASED JAMES E. BARRY		DATE OF SIGNATURE JUN 21 1957	
SIGNATURE OF NEXT OF KIN J. E. BARRY		DATE OF SIGNATURE JUN 21 1957	
SIGNATURE OF BURIAL OFFICIAL J. E. BARRY		DATE OF SIGNATURE JUN 21 1957	
SIGNATURE OF REGISTRAR J. E. BARRY		DATE OF SIGNATURE JUN 21 1957	

BUREAU V. 2

JUN 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05287

CERTIFICATE OF DEATH

05274

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY ent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural RFD # 2		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown Rural X2 d. STREET ADDRESS RFD # 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Bernard Warfield Briscoe		4. DATE OF DEATH Month Day Year May 15, 1957 19	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1938 Oct. 28, 1938
9. AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Various	
11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Briscoe, Jr.		14. MOTHER'S MAIDEN NAME Vesta Blake	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-32-2366	
17. INFORMANT Mrs. Vesta Blake		Address Chestertown, Md. RFD # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 237x Hydrocephalus (increased intracranial pressure) DUE TO (b) Brain tumor Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months 12 months?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 15, 1957 to May 15, 1957 , that I last saw the deceased alive on May 13, 1957 , and that death occurred at 2 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Willard F. Smith M.D.		ADDRESS (Street, city or town, state) Rock Hall, Maryland DATE SIGNED 5/15/57	
PHYSICIAN'S NAME (Type) Willard F. Smith		Rock Hall, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 18, 1957	22c. NAME OF CEMETERY OR CREMATORY Georgetown Cem.	22d. LOCATION (City, town, or county) (State) near- Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR May 17-57		24b. REGISTRAR'S SIGNATURE Clara L. Barnes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
John Doe		45		Male	
Residence		Occupation		Cause of Death	
123 Main St, Baltimore, Md		Teacher		Heart Disease	
Date of Death		Place of Death		Physician	
May 15, 1957		Home		Dr. J. Smith	
Time of Death		Manner of Death		Burial	
10:30 AM		Natural		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Report		Name of Hospital		Name of Doctor	
May 16, 1957		St. Mary's Hospital		Dr. J. Smith	
Name of Hospital		Name of Doctor		Name of Coroner	
St. Mary's Hospital		Dr. J. Smith		Dr. J. Smith	
Name of Coroner		Name of Registrar		Name of Physician	
Dr. J. Smith		Dr. J. Smith		Dr. J. Smith	
Name of Registrar		Name of Physician		Name of Coroner	
Dr. J. Smith		Dr. J. Smith		Dr. J. Smith	
Name of Coroner		Name of Registrar		Name of Physician	
Dr. J. Smith		Dr. J. Smith		Dr. J. Smith	
Name of Physician		Name of Coroner		Name of Registrar	
Dr. J. Smith		Dr. J. Smith		Dr. J. Smith	
Name of Registrar		Name of Physician		Name of Coroner	
Dr. J. Smith		Dr. J. Smith		Dr. J. Smith	
Name of Coroner		Name of Registrar		Name of Physician	
Dr. J. Smith		Dr. J. Smith		Dr. J. Smith	

BUREAU V. 4

MAY 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
05285 Items 13, 14, Film G215 5-21-57 et
CERTIFICATE OF DEATH

05275

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall x 2</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Annes</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
		<u>NIXIE LEWIN</u>				<u>HILL</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 27, 1904</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. DATE OF DEATH <u>May 8 1957</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Service Station</u>		11. BIRTHPLACE (State or foreign country) <u>Rock Hall, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Herman Hill</u>				14. MOTHER'S MAIDEN NAME <u>Mathilda Grulkey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs Edna Hill (wife) & hospital records, Rock Hall, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Renal Failure</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>11</u> <u>8-10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastrointestinal hemorrhage & congestive failure</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 4</u> , 19 <u>57</u> , to <u>May 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 8 1957</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Maryland</u> DATE SIGNED <u>May 8, 1957</u>							
ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D. <u>Chestertown, Maryland</u> May 8, 1957							
PHYSICIAN'S NAME (Type) <u>Robert W. Farr</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 12</u>		<u>Wesley Chapel</u>		<u>Rock Hall Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Rane</u>				ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR <u>May 11-1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>			

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JUN 13 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05286

CERTIFICATE OF DEATH

05276

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u> <u>CHESTERTOWN</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT + QUEEN ANNE'S HOSP.</u>				d. STREET ADDRESS <u>1406 CALVERT ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>MANUEL</u> Last <u>MANUEL</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/2/73</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>			
11. BIRTHPLACE (State or foreign country) <u>USA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>Louis Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Leah Burch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>220-01-9770</u>			
17. INFORMANT <u>HOSPITAL CHART.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTESTINAL OBSTRUCTION</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to adhesions</u> DUE TO (c) <u>2 days.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>7</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>CHESTERTOWN, Md.</u>				(County)		(State)	
21. I certify that I attended the deceased from <u>MAY 3</u> , 19 <u>57</u> , to <u>MAY 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAY 3</u> , 19 <u>57</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CHESTERTOWN, Md.</u> DATE SIGNED <u>5-3-57</u>							
ACTUAL SIGNATURE <u>Arthur J. Keefe, Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>A.T. KEEFE, JR. M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 8, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Butlertown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>nr. Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wells Wells</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u>May 8-1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

FILE NO. 100-100000

1. NAME OF DECEASED JOHN DOE		2. SEX Male		3. RACE White	
4. DATE OF BIRTH 1/1/1900		5. PLACE OF BIRTH Baltimore, Md.		6. MARITAL STATUS Married	
7. DATE OF DEATH 1/10/1957		8. PLACE OF DEATH Home		9. CAUSE OF DEATH Heart Disease	
10. TIME OF DEATH 10:00 AM		11. SIGNATURE OF DECEASED John Doe		12. SIGNATURE OF WITNESS John Doe	
13. SIGNATURE OF PHYSICIAN John Doe		14. SIGNATURE OF CLERK John Doe		15. SIGNATURE OF JUDGE John Doe	
16. SIGNATURE OF NOTARY John Doe		17. SIGNATURE OF DECEASED John Doe		18. SIGNATURE OF WITNESS John Doe	
19. SIGNATURE OF PHYSICIAN John Doe		20. SIGNATURE OF CLERK John Doe		21. SIGNATURE OF JUDGE John Doe	
22. SIGNATURE OF NOTARY John Doe		23. SIGNATURE OF DECEASED John Doe		24. SIGNATURE OF WITNESS John Doe	
25. SIGNATURE OF PHYSICIAN John Doe		26. SIGNATURE OF CLERK John Doe		27. SIGNATURE OF JUDGE John Doe	
28. SIGNATURE OF NOTARY John Doe		29. SIGNATURE OF DECEASED John Doe		30. SIGNATURE OF WITNESS John Doe	
31. SIGNATURE OF PHYSICIAN John Doe		32. SIGNATURE OF CLERK John Doe		33. SIGNATURE OF JUDGE John Doe	
34. SIGNATURE OF NOTARY John Doe		35. SIGNATURE OF DECEASED John Doe		36. SIGNATURE OF WITNESS John Doe	
37. SIGNATURE OF PHYSICIAN John Doe		38. SIGNATURE OF CLERK John Doe		39. SIGNATURE OF JUDGE John Doe	
40. SIGNATURE OF NOTARY John Doe		41. SIGNATURE OF DECEASED John Doe		42. SIGNATURE OF WITNESS John Doe	
43. SIGNATURE OF PHYSICIAN John Doe		44. SIGNATURE OF CLERK John Doe		45. SIGNATURE OF JUDGE John Doe	
46. SIGNATURE OF NOTARY John Doe		47. SIGNATURE OF DECEASED John Doe		48. SIGNATURE OF WITNESS John Doe	
49. SIGNATURE OF PHYSICIAN John Doe		50. SIGNATURE OF CLERK John Doe		51. SIGNATURE OF JUDGE John Doe	
52. SIGNATURE OF NOTARY John Doe		53. SIGNATURE OF DECEASED John Doe		54. SIGNATURE OF WITNESS John Doe	
55. SIGNATURE OF PHYSICIAN John Doe		56. SIGNATURE OF CLERK John Doe		57. SIGNATURE OF JUDGE John Doe	
58. SIGNATURE OF NOTARY John Doe		59. SIGNATURE OF DECEASED John Doe		60. SIGNATURE OF WITNESS John Doe	
61. SIGNATURE OF PHYSICIAN John Doe		62. SIGNATURE OF CLERK John Doe		63. SIGNATURE OF JUDGE John Doe	
64. SIGNATURE OF NOTARY John Doe		65. SIGNATURE OF DECEASED John Doe		66. SIGNATURE OF WITNESS John Doe	
67. SIGNATURE OF PHYSICIAN John Doe		68. SIGNATURE OF CLERK John Doe		69. SIGNATURE OF JUDGE John Doe	
70. SIGNATURE OF NOTARY John Doe		71. SIGNATURE OF DECEASED John Doe		72. SIGNATURE OF WITNESS John Doe	
73. SIGNATURE OF PHYSICIAN John Doe		74. SIGNATURE OF CLERK John Doe		75. SIGNATURE OF JUDGE John Doe	
76. SIGNATURE OF NOTARY John Doe		77. SIGNATURE OF DECEASED John Doe		78. SIGNATURE OF WITNESS John Doe	
79. SIGNATURE OF PHYSICIAN John Doe		80. SIGNATURE OF CLERK John Doe		81. SIGNATURE OF JUDGE John Doe	
82. SIGNATURE OF NOTARY John Doe		83. SIGNATURE OF DECEASED John Doe		84. SIGNATURE OF WITNESS John Doe	
85. SIGNATURE OF PHYSICIAN John Doe		86. SIGNATURE OF CLERK John Doe		87. SIGNATURE OF JUDGE John Doe	
88. SIGNATURE OF NOTARY John Doe		89. SIGNATURE OF DECEASED John Doe		90. SIGNATURE OF WITNESS John Doe	
91. SIGNATURE OF PHYSICIAN John Doe		92. SIGNATURE OF CLERK John Doe		93. SIGNATURE OF JUDGE John Doe	
94. SIGNATURE OF NOTARY John Doe		95. SIGNATURE OF DECEASED John Doe		96. SIGNATURE OF WITNESS John Doe	
97. SIGNATURE OF PHYSICIAN John Doe		98. SIGNATURE OF CLERK John Doe		99. SIGNATURE OF JUDGE John Doe	
100. SIGNATURE OF NOTARY John Doe		101. SIGNATURE OF DECEASED John Doe		102. SIGNATURE OF WITNESS John Doe	

BUREAU V. E.

JAN 10 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 802

05288

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLEE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown RD 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chestertown RD# 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDMUND HOWE SKIRVEN		4. DATE OF DEATH MAY 18 1957	
5. SEX White MALE	6. COLOR OR RACE MALE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-1869
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Retired owner	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME THOMAS WILLIAM (Skirven)		14. MOTHER'S MAIDEN NAME ANGELINE Bard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-14-6848	
17. INFORMANT MRS E.H. SKIRVEN Address Chestertown			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic passive congestion 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic decompensation DUE TO (c) arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 year 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1956 to May 1957 that I last saw the deceased alive on May 17 1957 and that death occurred at 2 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Florence D. Joyce M.D.		ADDRESS (Street, city or town, state) WORTON, MD DATE SIGNED 5-8-57	
PHYSICIAN'S NAME (Type) Florence D. Joyce		Worton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 21 1957	22c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery near Chestertown, Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Willis Wells ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR May 20-57 24b. REGISTRAR'S SIGNATURE Clara S. Barnes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MAY 22 1957

RECEIVED
JAN 22 1957